Key components of actinic keratosis pathway

Dermatology v1 (Clinician)

This is an overview of the key components needed to develop effective dermatology pathways and aims to help commissioners, managers and clinicians to see the overall shape of secondary care services for specific diseases or presentations. There are some examples (shaded blue) which may improve quality or efficiency. They do not provide detailed guidance on disease management or referral criteria (see www.bad.org.uk).

Patient seeks NHS help - Initial Referral	Triage	Assessment	Management	Outpatient / post acute follow up
Primary care can manage most AKs with topical treatments or no treatment in line with local, national BAD guidelines and PCDS guidelines	Advice and Guidance or teletriage. Full history and good quality images with dermoscopy may facilitate return to GP with advice or prioritise to appropriate OP assessment or direct surgery triage. Inefficient use of time if poor quality images or incomplete history (return referral). Images with face-on and lateral views can help distinguish AK from SCC. See Teledermatology Roadmap	Most seen in dermatology OP, some in plastics/ max-fax depending on skill mix and staffing: agree shared action plan: topical treatment/ cryotherapy/ photodynamic therapy (PDT) and usual disharge; biopsy or surgery or MDT discussion if possible cancer.		Most people with AK managed in community
Primary care referrer sends A&G request if diagnostic uncertainty or decides if lesion is higher enough suspicion of squamous cell carcinoma (SCC) or melanoma do 2WW referral	If 2WW criteria are met, then submission of macroscopic and dermascopic images with 2WW referral may enable dermatologist to diagnose AK virtually with telephone discharge. Currently pilots are assessing safety and efficacy with NHSEI.	Appropriately banded Skin Cancer Nurse involvement for education regarding topical treatment use for AK (and advice if lesion has progressed to SCC)		AK in people with transplants or immunosuppression may require long-term hospital surveillance ideally in specialist dermatology transplant clinics if high cancer risk
				Onwards referral to oncology/ radiotherapy/ palliative care for AKs that progress to advanced skin cancer as defined by MDT
				Optimise follow up arrangements

No treatment of AK with self-monitoring in community may be the best shared management plan, particularly for small lesions and if long-term life expectancy limited and if risks and discomfort of treatment outweigh benefits

GPwER support primary care with diagnosis and education and can help avoid hospital referral of most people with AKs

Empower patients and primary care to recognise and self treat with 5-FU cream.	Threshold policies should exclude referral of cosmetic lesions/ minor problems (exceptions such as immunosuppression)	High quality photography and WHO checklist reduce wrong site surgery never events	Same day surgery in one stop clinics for suitable people shortens patient pathway (may be with plastics/ max-fax)	Audit infection and biopsy rates. High rates require further analysis
Invest in education: AK GP education packages to include dermoscopy training		Confocal microscopy may in future replace skin biopsy for some lesions		
Monitor A&G + teletriage + total referral numbers to ensure that these do not escalate rapidly. A&G should be used to educate and improve primary care treatment of common conditions and not to shift care to secondary care		Super-clinics or spot clinics (multiple practitioners, nurses, junior doctors and GPwERs supervised by consultant without own list who sees nearly all patients) increases outpatient efficiency by reducing follow ups and ensuring all patients get consultant direct opinion		Follow up rarely necessary but when so PIFU may be appropriate

Appropriate use of digital technology throughout the pathway to improve patient experience rather than as an end in itself: see the dermatology digital playbook

Follow national specialist society (BAD/ BAPRAS etc) guidelines; NICE guidelines including audit and training recommendations

Clinician should encourage self-management and patient education using online resources – regarding sun protection, skin self monitoring for new or recurrent disease

Collect patient reported data and participate in relevant NIHR studies. Clinical research units usually have better outcomes.